Lowell Community Health Center
Health Information
161 Jackson Street, 2nd Floor
Lowell, MA 01852

978-322-8680 (phone) 978-446-9830 (fax) www.lchealth.org

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

We are required by law to obtain your written permission to release your medical information.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **TELEPHONE:** _____

CITY, STATE, ZIP: _____ **SOCIAL SECURITY #:** _____

1. I hereby authorize the release of the health records obtained in the course of my treatment at Lowell Community Health Center.

   To: Name: _____ For the time period: _____

   Address: _____ Reason for release: _____

   City, State, Zip: _____

2. The specific information to be released is: _____

3. If my initials appear here_____, I specifically authorize release of drug, alcohol abuse, sexually transmitted disease and/or counseling/psychiatric records. I understand that my drug treatment records are protected by under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Subpart C and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

4. If my initials appear here _____, I specifically authorize release of my records that contain information about my HIV diagnosis, tests or treatment of HIV and AIDS, and which may contain reference to my identity as HIV positive or as an AIDS patient.

5. I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information about, or health records of my condition to those persons of agencies named above.

6. 1 understand this authorization is subject to revocation at any time. Except to the extent that disclosure made in good faith has already occurred. Revocation must be made in writing. This authorization will expire 1 year from the date shown below.

7. Information released may be subject to re-disclosure by recipient.

_____
Health Record Number

_____ _____ _____
Date **Signature of patient or representative** **Authority or relationship of representative**

_____ _____
Date **Witness**

Please note that there may be a fee for reproducing copies of health records